Module #5: Trauma and Brain Neurobiology
Student Packet
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**Overview of Module**

This Module provides students with an overview of brain neurobiology. Students also will gain knowledge about the impact of developmental trauma and neglect on children. In this Module, we discuss the devastating impact that traumatic experiences can have on the child, altering their physical, emotional, cognitive and social development. Students will gain an understanding of how traumatic events in childhood increase the risk for a host of social, emotional, neuropsychiatric and physical health problems. This Module will address some of the key issues related to the child’s complex set of reactions that often follow traumatic events and how the adults in their lives can help them better understand the traumatic event and the ways that children and youth respond to the trauma.

**Learning Objectives**

Students will be able to:

1. Describe at least 3 of the fundamental processes of neurodevelopment.
2. List at least 3 of the key concepts of neurodevelopment.
3. Describe five factors that affect early brain development.
4. Describe the neurodevelopmental impact of neglect and traumatic stress in childhood.
5. Describe the mechanisms of hyperarousal and dissociation solution and their relationship to trauma.
6. Identify at least two clinical skills in using the principles of brain neurobiology in assessment.
7. Identify at least two clinical skills when intervening in response to the neurodevelopmental impact of:
   - Childhood neglect
   - Traumatic stress in childhood
   - Childhood PTSD
8. Identify at least 3 signs/behaviors that can be present in:
   - Adopted children who were previously maltreated
   - Adopted children with neglect-related attachment problems
9. Describe at least 3 critical principles for clinicians and caregivers to implement with children exposed to trauma
10. Describe at least two key processes that characterize the development of the adolescent brain.
Module #5: Trauma and Brain Neurobiology
Pre-Module Assignments

Student Assignment Checklist:

✓ Complete the training, The Amazing Brain and Human Development and develop talking points that you would use with the adoptive parent of a child exposed to early trauma.

Students’ Pre-Module Assignments


Using the knowledge you developed from the Child Trauma Academy training, write at least 6 or 7 talking points that you would use to help an adoptive parent understand the impact of early trauma on her child’s brain development. The child is 13 years old and was chronically neglected from birth to 6 months of age when she entered foster care. The family adopted her at age 6. Now that she is entering adolescence, she is having increasingly serious emotional and behavioral challenges.

Provide your talking points to your teacher. Bring a copy of your talking points with you to class.

OPTIONAL TRAINING: A training Module, Psychotropic Medications and Children and Adolescents, is available on the C.A.S.E. website. You are encouraged to complete this training and/or use it as a resource in your clinical work.
# Module #5: Trauma and Brain Neurobiology

## Agenda

<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
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<tbody>
<tr>
<td>9:00AM – 9:10AM</td>
<td>Welcome</td>
</tr>
<tr>
<td>9:10AM – 9:45AM</td>
<td>The Fundamental Processes of Neurodevelopment</td>
</tr>
<tr>
<td>9:45AM – 10:00AM</td>
<td>Key Concepts of Neurodevelopment</td>
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<tr>
<td>10:00AM – 10:15AM</td>
<td>Break</td>
</tr>
<tr>
<td>10:15AM – 11:15PM</td>
<td>The Impact of the Social Environment on Brain Development</td>
</tr>
<tr>
<td>11:15PM – 12:30PM</td>
<td>Understanding the Impact of Trauma on the Developing Child: A Focus on</td>
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<tr>
<td></td>
<td>Neglect -- Assessment (Part 1)</td>
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<tr>
<td>12:30PM – 1:30PM</td>
<td>Lunch</td>
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<tr>
<td>1:30PM – 1:50PM</td>
<td>Understanding the Impact of Trauma on the Developing Child: A Focus on</td>
</tr>
<tr>
<td></td>
<td>Neglect -- Assessment (Part 2)</td>
</tr>
<tr>
<td>1:50PM – 2:10PM</td>
<td>Understanding the Impact of Trauma on the Developing Child: A Focus on</td>
</tr>
<tr>
<td></td>
<td>Neglect -- Intervention</td>
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<tr>
<td>2:10PM – 3:30PM</td>
<td>Understanding the Impact of Trauma on the Developing Child: A Focus on</td>
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<td></td>
<td>Violence</td>
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<td></td>
<td>[Break to be provided]</td>
</tr>
<tr>
<td>3:30PM – 4:15PM</td>
<td>Adolescent Brain Development</td>
</tr>
<tr>
<td>4:15PM – 4:30PM</td>
<td>Closing</td>
</tr>
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Reading List

Web-Based Resources


Other Resources


Resources on Adolescent Brain Development


Resources on Psychotropic Medications


Module #5: Trauma and Brain Neurobiology
Handout #5.1 Templates for Future Relationships

CLARA: Clara was born when her mom was only 15. She lived with her mom and her mom’s boyfriend for six years. Her mom and the boyfriend used and sold drugs. There were always strangers in and out of the home. Clara often received the brunt of her mother’s anger and frustration. Her mom yelled at her and there were often drunken fights in the apartment. When this happened, Clara retreated to a corner of the basement where she kept a special doll. When Clara was 6, she entered foster care. Her parents’ rights were terminated and at age 10, Clara was adopted by Connie and Dave Brown.

What is Clara’s “template for future relationships”?

JACOB: Ruth and Tom adopted Jacob from an orphanage in Russia. He entered the orphanage when he was 2 days old because his mother knew that she could not care for him financially. When she signed the relinquishment papers, she left him a 4 page hand written letter. While in the orphanage, Jacob received minimal, but adequate caregiving. Within 2 months, he was placed with Ruth and Tom in the U.S. -- they are a professional couple who are unable to have children of their own.

Jacob was the second child that had been placed with Ruth and Tom. The first child, a 2 month old little boy in foster care, had been with them for 6 months but was removed when a family member came forward who wanted to raise him. They were hesitant to get too attached to Jacob fearing history might repeat itself. Try as they might to protect themselves, Ruth and Tom quickly grew to love Jacob. Ruth took him to “mommy and me” classes and both Ruth and Tom showered him with time, touch and love.

What is Jacob’s “template for future relationships”?

SAMANTHA:
Part 1: Samantha was taken to the hospital by a neighbor who lived in the apartment next to her mother. She had a broken femur and collarbone. The ER doctor was not surprised by the results of the x-rays – healing fractures of different ages. Samantha was only 2 ½ years old. She was released by the hospital to a CPS caseworker. When the worker picked up the little girl, Samantha did not cling or look at her. She didn’t make a sound on the 45-minute ride to her new foster family’s home. The caseworker thought she was simply overwhelmed by all that had taken place over the last few weeks.

What is Samantha’s “template for future relationships”? 
Part 2: The foster mother who met them at the door was a sweet older woman with a silent joy about her. She gently took Samantha in her arms and held Samantha’s face close to hers whispering softly into her ear that she was safe now. As the caseworker left, Samantha was being slowing rocked in the cradling arms of her foster mother.

How might Samantha’s emerging “template for future relationships”? 
How the Brain Responds to a Traumatic Event

Bruce D. Perry, MD, Ph.D.

This sequence developed by Dr. Bruce Perry shows how the brain responds to a traumatic event. Notice that with a prolonged alarm reaction, the child will experience an altered neural state. The longer the child remains in a persistent state of fear, the more likely it is that the child’s brain will change to reflect these experiences.

1. How have you encountered altered neutral states in children and adolescents with whom you worked? What were these children’s and youth’s histories of trauma?
### Acute Response to Threat

**The Child Trauma Academy**  
Copyright 2005 Bruce D. Perry, MD, Ph.D.

<table>
<thead>
<tr>
<th>Sense of Time</th>
<th>Extended Future</th>
<th>Days Hours</th>
<th>Hours Minutes</th>
<th>Minutes Seconds</th>
<th>Loss of Sense of Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary brain areas</td>
<td>Neocortex</td>
<td>Subcortex</td>
<td>Limbic</td>
<td>Midbrain</td>
<td>Brainstem</td>
</tr>
<tr>
<td>Secondary brain areas</td>
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<td>Subcortex</td>
<td></td>
<td>Midbrain</td>
<td>Brainstem</td>
</tr>
<tr>
<td>Cognition</td>
<td>Abstract</td>
<td>Concrete</td>
<td>Emotional</td>
<td>Reactive</td>
<td>Reflexive</td>
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<tr>
<td>Mental state</td>
<td>CALM</td>
<td>AROUSAL</td>
<td>ALARM</td>
<td>FEAR</td>
<td>TERROR</td>
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This chart developed by Dr. Perry depicts how we (all of us) respond to threat. When threatened, we all move along the arousal continuum – from calm to aroused, aroused to being alarmed, from alarm to fear and from fear to terror. As we move along this continuum, different areas of our brain are in control. The more threatened we become, the more regressed or primitive our manner of thinking becomes. Not surprisingly, when a traumatized child is in a state of alarm, due to some reminder of past trauma, for example, the child will be less capable of concentrating, will become more anxious and will focus more on non-verbal than verbal cues. As the child continues to become more anxious and fearful, she will become more and more reactive. This become particularly important as we look at the implications for understanding the way a traumatized child is processing information, learning and reacting in a given situation (Perry, 2005).

2. What responses to trauma have you observed in the children and youth with whom you have worked? What changes have you seen in:
   a. Cognition
   b. Affect
   c. Behavior
   d. Physiology either through:

   *Hypervigilance*: the child’s sensory sensitivity accompanied by an *exaggerated* intensity of behaviors with the purpose of detecting threats;
accompanied by a state of increased anxiety, high responsiveness to 
stimuli, and a constant scanning of the environment for threats. 
Dissociation: the child’s withdrawal of attention from the outside world 
and focus on the inner world
Handout #5.3: Childhood Trauma, the Neurobiology of Adaptation, and “Use-dependent” Development of the Brain: How “States” Become “Traits”

[this article is in pdf format and is posted on the C.A.S.E. website]
Handout #5.4 Results From Andrey’s Developmental Assessment

Results from Andrey’s developmental assessment showed delays in every domain due to early, pervasive sensory neglect.

Speech and language was severely delayed (expressive and receptive)
- Because Andrey did not consistently hear speech (i.e., he wasn’t talked to and interacted with by the adults around him), he missed the critical window related to language development
  - NOTE: the **only** way we learn language is by hearing it and because Andrey didn’t hear sound as he should have some sounds he would never be able to make

Fine and gross motor delays
- Because he spent most of this early life in a crib, without access to open spaces where he could crawl, walk and run, Andrey’s gross motor skills were underdeveloped
- Fine motor skills like holding a pencil were also delayed due to lack of opportunity

Delayed social and emotional development
- Andrey lacked a secure, safe, healthy attachment to a primary caregiver during his years in the orphanage so deficits in these areas are not surprising.
- His diminished self-regulatory capabilities only further added to his problems with peers (social development) who labeled him as weird.
Handout #5.5 Sasha’s Case

Sasha was adopted from the foster care system through a private agency when she was 2 years old. Her adoptive parents already had a son, age 5 and a half. Sasha was removed from her home at the age of 9 months due to physical abuse of her 4 year old sister, Kendra. Her mother and her boyfriend were arrested and ultimately convicted for causing life threatening injuries to Kendra. Once in custody, it was discovered that Sasha had also sustained injuries. She was found to have multiple fractures in various stages of healing.

Sasha and Kendra were placed in a foster/adoptive home. The plan was that as soon as their mother’s parental rights were terminated, the girls would be adopted by the family who had already been caring for them.

Unfortunately, Kendra had serious behavioral problems and the parents were unable to control her. While they still wanted to adopt Sasha, they were no longer interested in Kendra. Because CPS was committed to keeping the siblings together, they were both removed from home.

By the time the biological mother’s rights had been terminated just 6 months later, Kendra was in a psychiatric hospital and Sasha was in her third placement.

Finally, after 14 months in foster care Sasha was finally placed with an adoptive family. She was now 25 months old.

Sasha was not quite what her adoptive parents expected. She is a beautiful little girl whose eyes speak volumes. Her mother describes how she follows people with her eyes – always watchful. She rarely smiles. Her mother described an experience shortly after Sasha came to live with them. The mom was laying on the floor with Sasha playing with a stuffed puppy, tickling Sasha and making barking sounds. Sasha just stared at her intently. Then out of nowhere, Sasha grabbed the animal, threw it, then screamed and ran into another room. They described her as very suspicious. Even when they tried to rock her to sleep, she wouldn’t close her eyes.

While Sasha has grown more comfortable in her environment she still struggles with trusting her new parents.

Sasha was brought to the clinic following her expulsion from pre-school. Sasha had been with her adoptive family for less than a year and her new parents realized that they neither understood or were equipped to handle her behaviors. Age at intake – 33 months.
Presenting problems:

- Night terrors
- Impulsive behaviors, hoarding foot, stealing
- Easily startled and always “on edge”
- Sometimes seems to not hear what they are saying
- Aggressive/violent with parents and other children
- Didn’t smile or seem to enjoy toys

- If Sasha were brought to you for assessment and treatment, where would you begin? What questions would you ask? What data would you like to see? How would you make decisions about treatment?

- What types of assessments might you conduct?

- What would you like to know from Sasha’s foster care records
Therapeutic interventions with children exposed to trauma should:

- Be based on the unique strengths and vulnerabilities of each child
  
  How we do this:

- Have the primary objective of therapeutic activities to ensure that experiences are “relevant, relational, repetitive and rewarding” (Perry)
  
  How we do this:

- Ensure that activities are provided within the context of healthy relationships with safe, predictable and nurturing adults
  
  How we do this:

- Are provided in a sequence that closely resembles normal development.
  
  How we do this:
Handout #5.7 Conditions and Behaviors Seen in Maltreated Children who Have Been Adopted

- **Developmental delays** – the bond between the young child and caregiver provides the major vehicle for their development
  
  Lack of consistent and enriched experiences in early childhood can result in lags in physical, motor, language, emotional, social and cognitive development

- **Atypical eating behaviors** – atypical eating behaviors are common, especially in children with severe neglect and attachment problems
  
  May hoard food, hide food in their rooms, eat as if it is their last meal

- **Soothing behavior** – child may be very primitive, immature and have seemingly bizarre soothing behaviors
  
  May scratch or cut themselves, bite themselves, head bang, rock, or chant (these symptoms increase during times of stress)

- **Inappropriate Modeling** – children model adult behavior – even if it is inappropriate
  
  May have learned that abusive behavior is the “right” way to interact with others

- **Aggression** – a major problem with neglected, poorly attached children is aggression and cruelty.
  
  The result of two major problems in neglected children:
  
  - Lack of empathy
  - Poor impulse control

- **Psychological or Behavioral Problems**
  
  Conscience Development
  
  - May not show normal anxiety following aggressive or cruel behavior
  
  - May not show guilt on breaking laws or rules
  
  - May project blame on others

  Impulse Control
  
  - Exhibits poor control; depends upon others to provide control
  
  - Exhibits lack of foresight
  
  - Poor attention span

  Self-Esteem
  
  - Unable to get satisfaction from tasks well done
  
  - Sees self as undeserving
  
  - Sees self as incapable of change
  
  - Has difficulty having fun

- **Problems in interpersonal reactions**
  
  - Lacks trust in others
  
  - Demands affection but lacks depth in relationships
• Exhibits hostile dependency
• Needs to be in control of all situations
• Has impaired social maturity

➤ Emotional functioning challenges
• Has trouble recognizing own feelings
• Difficulty expressing feelings appropriately: especially anger, sadness and frustration
• Has difficulty recognizing feelings in others
Handout #5.8 Trauma Interventions Rated by the California Evidence Based Clearinghouse for Child Welfare

Scientific Rating 1: Well Supported by Research Evidence

**EMDR**

The information in this program outline is provided by the program representative and edited by the CEBC staff. The *Eye Movement Desensitization and Reprocessing (EMDR)* program has been rated by the CEBC in the area of: Trauma Treatment (Child & Adolescent).

**Types of Maltreatment:** Physical Abuse, Sexual Abuse, Physical Neglect, Emotional Abuse, Exposure to Domestic Violence

**Target Population:** Children and adults who have experienced trauma. Research has been conducted on Post-Traumatic Stress Disorder (PTSD), post-traumatic stress, phobias, and other mental health disorders.

**EMDR** is an 8-phase psychotherapy treatment that was originally designed to alleviate the symptoms of trauma. During the **EMDR** trauma processing phases, the client attends to emotionally disturbing material in brief sequential doses that include the client’s beliefs, emotions, and body sensations associated with the traumatic event while simultaneously focusing on an external stimulus. Therapist directed bilateral eye movements are the most commonly used external stimulus but a variety of other stimuli including hand-tapping and audio bilateral stimulation are often used.

**TF-CBT**

The information in this program outline is provided by the program representative and edited by the CEBC staff. The *Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT)* program has been rated by the CEBC in the areas of: Anxiety Treatment (Child & Adolescent) and Trauma Treatment (Child & Adolescent).

**Types of Maltreatment:** Sexual Abuse, Exposure to Domestic Violence

**Target Population:** Children with a known trauma history who are experiencing significant Post-Traumatic Stress Disorder (PTSD) symptoms, whether or not they meet full diagnostic criteria. In addition, children with depression, anxiety, and/or shame related to their traumatic exposure. Children experiencing Childhood Traumatic Grief can also benefit from the treatment.

**TF-CBT** is a conjoint child and parent psychotherapy model for children who are experiencing significant emotional and behavioral difficulties related to traumatic life events. It is a components-based hybrid treatment model that incorporates trauma-sensitive interventions with cognitive behavioral, family, and humanistic principles.
The overall goal of **TF-CBT** is to address symptoms resulting from a specific traumatic experience or experiences. This includes:

- Improving child PTSD, depressive and anxiety symptoms
- Improving child externalizing behavior problems (including sexual behavior problems if related to trauma)
- Improving parenting skills and parental support of the child, and reducing parental distress
- Enhancing parent-child communication, attachment, and ability to maintain safety
- Improving child's adaptive functioning
- Reducing shame and embarrassment related to the traumatic experiences

**Scientific Rating of 2: Supported by the Research Evidence**

**CPP**

The information in this program outline is provided by the program representative and edited by the CEBC staff. The *Child-Parent Psychotherapy (CPP)* program has been rated by the CEBC in the areas of: Domestic/Intimate Partner Violence: Services for Women and their Children, Infant and Toddler Mental Health (0-3) and Trauma Treatment (Child & Adolescent).

- **Types of Maltreatment:** Physical Abuse, Sexual Abuse, Physical Neglect, Exposure to Domestic Violence
- **Target Population:** Children age 0-5, who have experienced a trauma, and their caregivers.

**CPP** is a treatment for trauma-exposed children aged 0-5. Typically, the child is seen with his or her primary caregiver, and the dyad is the unit of treatment. **CPP** examines how the trauma and the caregivers’ relational history affect the caregiver-child relationship and the child’s developmental trajectory. A central goal is to support and strengthen the caregiver-child relationship as a vehicle for restoring and protecting the child’s mental health. Treatment also focuses on contextual factors that may affect the caregiver-child relationship (e.g., culture and socioeconomic and immigration related stressors). Targets of the intervention include caregivers’ and children’s maladaptive representations of themselves and each other and interactions and behaviors that interfere with the child’s mental health. Over the course of treatment, caregiver and child are guided to create a joint narrative of the psychological traumatic event and identify and address traumatic triggers that generate dysregulated behaviors and affect.

**PE-A**

The information in this program outline is provided by the program representative and edited by the CEBC staff. The *Prolonged Exposure Therapy for Adolescents (PE-A)*
program has been rated by the CEBC in the areas of: Anxiety Treatment (Child & Adolescent) and Trauma Treatment (Child & Adolescent).

**Types of Maltreatment:** Physical Abuse, Sexual Abuse

**Target Population:** Adolescents who have experienced a trauma (e.g., sexual assault, car accident, violent crimes, etc). The program has also been used with children 6 to 12 years of age and adults who have experienced a trauma.

*PE-A* is a therapeutic treatment where clients are encouraged to repeatedly approach situations or activities they are avoiding because they remind them of their trauma (in vivo exposure) as well as to revisit the traumatic memory several times through retelling it (imaginal exposure). Psychoeducation about common reactions to trauma as well as breathing retraining exercises are also included in the treatment. The aim of in vivo and imaginal exposure is to help clients emotionally process their traumatic memories through imaginal and in vivo exposure. Through these procedures, they learn that they can safely remember the trauma and experience trauma reminders, that the distress that initially results from confrontations with these reminders decreases over time, and that they are capable of tolerating this distress.

The overall goal of *Prolonged Exposure Therapy for Adolescents (PE-A)* is to promote the client’s ability to emotionally process their traumatic experiences and consequently diminish PTSD and other trauma-related symptoms.

**Scientific Rating of 3: Promising Research Evidence**

- Alternatives for Families: A Cognitive-Behavioral Therapy (AF-CBT)
  - Topics: Trauma Treatment (Child & Adolescent)
  - Caregivers who are aggressive and physically, emotionally, or verbally abuse their children and their children who experience behavioral dysfunction, especially ...
- Cognitive Behavioral Intervention for Trauma in Schools (CBITS)
  - Topics: Anxiety Treatment (Child & Adolescent), Trauma Treatment (Child & Adolescent)
  - 3rd through 8th grade students who screened positive for exposure to a traumatic event and symptoms of post-traumatic stress disorder ...
- I Feel Better Now! Trauma Intervention Program
  - Topics: Trauma Treatment (Child & Adolescent)
  - At-risk children ages 6-12 with a history of trauma or loss.
- Sanctuary Model
  - Topics: Higher Level of Placement, Trauma Treatment (Child & Adolescent)
  - This program is not a client-specific intervention, but a full-system approach that targets the entire organization.
- Seeking Safety for Adolescents
  - Topics: Substance Abuse Treatment (Adolescent), Trauma Treatment (Child & Adolescent)
  - Adolescents with a history of trauma and/or substance abuse.
• SITCAP-ART
  o Topics: Trauma Treatment (Child & Adolescent)
  o At-risk and adjudicated youth, ages 12-17, with a history of trauma and/or loss.
• Trauma-Focused Coping (TFC)
  o Topics: Trauma Treatment (Child & Adolescent)
  o Children and adolescents in schools who have suffered a traumatic exposure (e.g., disaster, violence, murder, suicide, fire, accidents)
Handout #5.9  Final Points on Treatment For Children Exposed to Trauma from the Child Trauma Academy

For Clinicians and Caregivers

➢ Nurture, nurture, nurture
  • These children need to be held and rocked and cuddled
  • Be aware of what touch may have meant to these children in the past (pain, torture, abuse)
  • Be “attuned” to their responses to your nurturing and act accordingly
  • In many ways you are providing replacement experiences that should have taken place during infancy but you are doing it at a time when their brains are harder to modify
    • Therefore, they will need even more bonding experiences to help develop attachments

Having relationships with attuned adults is an important factor in children’s growth following early developmental trauma. Attuned caregivers learn to read cues (e.g., I don’t want you to hug me – or I’m not ready for you to hug me) and learn to adjust (e.g., ok – you’re not ready for me to hug you -- how about I brush your hair? Or pat your hand or stroke your back?) They are patient – unwilling to give up no matter how long it takes. The same goes for clinicians.

➢ Try to understand behavior before dispensing punishment or consequences
  • The more you can learn about the impact of trauma on relationships, bonding, normal development and abnormal development the better you will be able to develop useful behavioral and social interventions

➢ Provide parenting based on the child’s emotional age
  • Abused and neglected children will often be emotionally and socially delayed
  • Stay “in-tune” with the child and meet him/her where he or she is.

➢ Be consistent, predictable and repetitive
  • Maltreated children with (and often without) attachment problems are very sensitive to transitions, surprises, chaotic social situations, changes in schedules, and in general any new situation
  • When children feel safe and secure they can benefit from the nurturing, enriching emotional and social experiences provided to the.

➢ Model and teach appropriate social behaviors
• Coaching, teach social skills based upon appropriate developmental level

**Always, always, always** remember to provide treatment based upon the developmental age of the child. A child may be 10 chronologically but 3 socially. Placing this child in a large group activity would be setting them up to fail. Think about what kind of interaction would be appropriate for a 3 year old – dyadic relationships – so a group with one (or two at the most) other children will be most effective

- Listen and play with these children
  - When you are quiet and interactive with them, you find that they will begin to show you and tell you about what is really inside of them
  - They will sense that you are there just for them – they will feel how you care
- Have realistic expectations of these children
  - Comprehensive evaluations can be very helpful in beginning to define the skill areas of a child and the areas where progress will be slower
- Be patient with the child’s progress and with yourself
- Take care of yourself and take advantages of other resources

Encourage parents to actively seek respite and participate in self-care strategies. They will be a better parent if they are more relaxed and less stressed out. Caring for a traumatized child is exhausting, difficult work. Validate their struggles and help remind them of the good job they are doing. Help them identify other safe, caring, nurturing adults (whether family members or close friends) who can also be a source of support for their child and the family; someone the child is comfortable with and who can provide some time for the parent(s) to have a quite dinner out, go to a movie or just sleep. Clinicians must also practice good self-care so that they can continue to do this important work.

Resources for neurodevelopment information:

- [www.childtrauma.org](http://www.childtrauma.org)
  - [http://www.childtrauma.org/ctamaterials/Neuroarcheology.asp](http://www.childtrauma.org/ctamaterials/Neuroarcheology.asp)
- [http://www.traumacenter.org/about/about_bessel.php](http://www.traumacenter.org/about/about_bessel.php)
- [www.trauma-pages.com](http://www.trauma-pages.com)